

**STATE OF WEST VIRGINIA
HUMAN RIGHTS COMMISSION**
Room 108A, 1321 Plaza East, Charleston, WV 25301-1400
Ph: (304) 558-2616 Fax: (304) 558-0085 Toll Free: (888) 676-5546 www.hrc.wv.gov
*** (INTERNET FORM) ***

PUBLIC ACCOMMODATIONS
PRE-COMPLAINT BACKGROUND FORM

Please do your best to provide complete answers to each of the following questions. If a question does not apply to your situation, mark that question as n/a or not applicable.

NOTICE: THIS IS NOT A CONFIDENTIAL DOCUMENT. A copy of this questionnaire, containing your answers and any statements and attachments you provide, may be released to anyone who submits a proper request, including the responding entity. **Do not attach documents, such as medical records, to this form.**

Today's Date: _____

Your Complete Contact Information

It is important that the Commission be able to reach you. If your contact information changes, please let the Commission know immediately.

Mr. ___ Miss ___ Mrs. ___ Ms. ___ Full Name _____
Street Address _____ City _____
County _____ State _____ Zip _____ E-mail _____
Phone (home) _____ (work) _____ (cellular) _____
Date of Birth _____ Age _____ Sex _____ Race _____ National Origin _____
The best time to call me is: **Mornings** ___ **Afternoons** ___. The best number to call is _____.

Your Legal Representation

You do not need an attorney to file a complaint. However, if you are represented by a lawyer, please provide the attorney's contact information and ask your lawyer to submit a written notice of representation.

Lawyer Name _____
Law Firm _____
Address _____
City _____ State _____
Zip _____ Ph _____

Other Complaints You Have Filed

Have you filed **this same complaint or charge** with:
another agency? Yes ___ No ___
in state or federal court? Yes ___ No ___

Have you ever filed **any complaint** here before?
Yes ___ No ___
Approximate date(s) you filed _____
Docket Number(s) _____
Who did you file against? _____

Your Emergency Contact Information

Please provide contact information for a family member or friend, **who does not share your address or telephone number(s)**, and who can reach you or get a message to you if the Commission is unable to contact you.

Name _____
Relationship to you _____
Street Address _____
City _____
State _____ Zip _____
Ph (h) _____ (cell) _____

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The term "**place of public accommodations**" means any establishment or person which offers its services, goods, facilities, or accommodations to the general public. This includes "private" facilities and programs which are open to the public, and state and local governmental agencies and programs.

Who Is Your Complaint Against?

Who do you believe discriminated against you?

<input type="checkbox"/> State or Local Government	<input type="checkbox"/> Shopping Center
<input type="checkbox"/> School	<input type="checkbox"/> Club
<input type="checkbox"/> Restaurant	<input type="checkbox"/> Recreational Venue
<input type="checkbox"/> Nightclub	<input type="checkbox"/> Health Care Provider
<input type="checkbox"/> Bank or Lending Agency	<input type="checkbox"/> Religious Institution
<input type="checkbox"/> Store	<input type="checkbox"/> Transportation Service
<input type="checkbox"/> Hotel/Motel	<input type="checkbox"/> Other (specify) _____

Please provide the full name and contact information for the entity you want to name in your public accommodations complaint. Be as specific as possible.

Full Name of Entity _____
 Address _____
 City _____ State _____ Zip _____
 County _____ Ph _____ Fax _____

Where did the discrimination happen? If the place the discrimination happened is different than the address you have given for the entity you want to name in your complaint, please provide the address or description of the place where the harm occurred.

Full Name of Place _____
 Address _____ City _____ State _____ Zip _____
 County _____ Ph _____ Fax _____

IMPORTANT NOTICE: Completing and returning this form **DOES NOT** mean you have filed a complaint. Additional steps must be taken to file a formal complaint with the HRC. It is vital that you submit this form well before the 365 day deadline to ensure that your complaint is completed on time. **If you are submitting this form within one month of your 365 day filing deadline, please call the West Virginia Human Rights Commission for further instructions.**

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What Happened?

Please **check** each type of harm that applies to your situation and provide the **date(s)** upon which the alleged unfair treatment occurred.

✓	Type of Harm	Date(s) of Harm
	Refused Admission	
	Denial or Partial Denial of Service	
	Unequal Access, Service, or Treatment	
	Failure to Accommodate	
	Inaccessible Facilities	
	Hostile Environment (only if motivated by Sex, Race, Color, Age, National Origin, Ancestry, Religion and/or Disability)	
	Other	

If you claim you were racially or sexually harassed, were you harassed by

- a proprietor, owner, or manager of a place of public accommodations?
- an employee of a place of public accommodations?
- unknown
- other (describe _____)

For each person whom you claim harassed you, please provide his or her name, job title and address, if known.

Name _____
Job Title _____
Address _____
City _____ State _____
Zip _____ Ph _____

Alleged Unlawful Bias

What do you believe motivated your unfair treatment? Check **ALL** the factors that you believe **actually apply** to your situation.

- | | |
|--------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Race | <input type="checkbox"/> Ancestry |
| <input type="checkbox"/> Color | <input type="checkbox"/> National Origin |
| <input type="checkbox"/> Sex | <input type="checkbox"/> Religion |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Disability/Blindness |
| <input type="checkbox"/> Age (40 or older) | <input type="checkbox"/> Retaliation for opposing unlawful discrimination |

If you believe your unfair treatment was motivated by **disability** discrimination, please provide the following information.

Check all that apply:

- I have a disability.
 I had a disability in the past.
 I do not have a disability, but the place of public accommodations treats/treated me as if I do have a disability or regards me as disabled.

My **disability** is: _____

If you believe your unfair treatment was motivated by your **color**, please describe your color.

If you believe your unfair treatment was motivated by your **ancestry**, please identify your ancestry.

If you believe your unfair treatment was motivated by your **religion**, please identify your religious affiliation, if any.

If you believe your unfair treatment was motivated by **retaliation** for your efforts to oppose unlawful discrimination, please provide the following information.

Was your unfair treatment motivated by:

- a. having previously assisted the Commission in an investigation? Yes No
- b. having complained to the place of public accommodations about unlawful discrimination? Yes No
- c. having filed a previous complaint with the Commission? Yes No

